Today's psychosomatic medicine can be better understood, if viewed against its historical background, the root of which reach back to the origins of western medicine in Greece at the fifth century B.C. (Lipowski 1977). Before its present form as an organized field many themes of psychosomatic research and theory recurrently addressed over the centuries e.g. Gaub (1747) in Leyden wrote that - "the reason why a sound body becomes ill, or an ailing body recovers, very often lies in the mind. Contrariwise, the body can frequently both beget mental illness and heal its offspring". Gaub reported the ill effect of fear, rage, joy, unexpressed sorrow and suppressed anger on the body. In 1818 the term psychosomatic was first used by J.C.A. Heinorth when he discussed psychosomatic factor in insomnia and from then this was popularised by the German psychiatrist K.W.M., Jacobi (1822). Although Jacobi favoured somatic orientation and used the term Somatopsychic, Psychobiographical and psychosomatic medicine were developed by G.W. Grodeck (1866-1937) and was considered father of this by someone.

The groundwork for a new science was laid by Tuke in 1872. He compiled the disorganised and scattered information regarding the influence of the mind on the body in health and disease in a coherent theoretical framework. The empirical study of mind body problems remain stagnant in the late nineteenth century. The present concept of the term has its origin in psychoanalysis and physiology - this indicates an attempt to regard man as monistic. The founding of the American psychosomatic Society in 1939 and its journal represented an attempt to correlate psychological and psychoanalytical concepts with biological process, the impetus of which was from Cannon's work on the Physiological accompaniment of emotion. The Academy of Psychosomatic Medicine was founded in 1953, as the founders believed that psychosomatic medicine belonged to all medicines, not only the property of Psychoanalyst and Research workers in this field. Wolff (1970) thus remarked that most of the diseases are multifactorial in origin and psychological and somatic interaction should be considered in each patient who is ill.
The American Medical Association and American Psychiatric Association separately grouped psychosomatic illness between psychotics and psychoneurotic disorders for studying accurately the course, etiology and relation to other mental illnesses.

The American Psychiatric Association (A.P.A.) faced with some of the semantic difficulties dispensed with the term Psychosomatic in 1952. The term was substituted with psychophysiologic autonomic and visceral disorder in the standard Nomenclature. This group also included disorders that are classified as organ neurosis or 'anxiety neurosis', 'gastric neurosis' and so forth. The distinction between bodily manifestation of psychophysiologic disorder and state of anxiety is made on the basis of persistent and predominant involvement of single organ system.

Inspite of all these efforts to avoid the term psychosomatic, it remained and been used in all recent literatures.

Draper (1944) deprecated the dual nature of the term psychosomatics, the idea of mind and body interaction. He described psyche as life force inhering in each cell from the time of conception up to death.

Targowla's (1949) approach was more sceptical towards the systematic elaboration of 'psychosomatic Medicine' by the American workers. He considered that this was nothing more than rediscovery of hysteria which was left by Freud in 1895. He believed that the fate of psychosomatic medicine might suffer the same as hysteria in its time, in being exposed to the theories that are illusive, artificial and insufficiently scientific.

Lewis (1954) concluded "It is best to recognise that psychosomatic refers to an ill defined area of interest with constantly changing boundaries in which there are manifest relations between events best studied by psychological methods and best studied by physiological method".

Margolin and Kaufman described psychosomatic medicine as an operational approach to the theory of practice of medicine in which the structure and function of the psychic apparatus are dealt
With as variable in health & disease, just e.g. are physiology and pathology (X.X. Greker, J.R. Ewalt, et al.; Baumgarten, 1957).

Sternbach (1966) holds the view that all illness are psychosomatic but some of them have more emotional aspects then other.

In 1968, in the 2nd edition of the Diagnostic Statistical Manual of Mental Disorders (DSM-II), they used psychophysiologic disorders, which implies that this group of physical disorder presumably of psychogenic origin has main impact on the internal organ or visceras, precipitated by emotional or psychological stress involved a single organ system which is generally under autonomic nervous system innervation.

According to Lazarus (1968), the field that concerned with the link between psychological problem and somatic disorder is called psychosomatic illness.

But every one does not mean the same thing by the term psychosomatic disorder. To many the term was used to express a vague admission that a patient has both body and mind, so both are given due attention.

According to Tucker (1970) there are some bodily disorders that seem to be associated with life events of an individual that do not innately generate pathology. Inherited bodily illness in response to psychological events may have to do with life experiences of individuals, are called psychosomatic disorders.

Physical illness is the most socially acceptable excuse for incapacity. In symptom of physical disease the neurotic individual frequently finds solution to frustration & anxiety; when the symptoms of physical illnesses are considered to be psychogenic, the illnesses are said to be psychosomatic.
CLASSIFICATION:

The A.P.A. introduced a classification in their edition (DSM-III), of psychological factors in physical condition. This includes:

1. The traditional psychosomatic illness.
2. Any illness that is diagnosed as psychophysiological disorders under the criteria of (DSM-III).
3. The physical condition in which psychological factor plays an important role in precipitating, aggravating & perpetuating the illness (Looney, Lipp & Spitzer 1977).

Stalker (1949) agreed with Weiss and English in Classifying the psychosomatic problems into three divisions. The first group consisted of the functional disorders. The symptoms of patients in 2nd group were in part dependent upon emotional factors even in presence of organic disease. The third group covered those diseases that are considered to be within the categories of physical disease associated with ANS. Stalker assigned the third group to psychosomatic medicine.

However, there is not universal agreement as to which condition should be included as being psychosomatic, but the following brief list (in system) is generally accepted (Eysenck 1972).

1. RESPIRATORY :: Asthma, Vasometer rhinitis
2. GASTROINTESTINAL :: Peptic Ulcer, Colonic disorders.
3. CARDIOVASCULAR :: Hypertension, Coronary disease, Migraine
4. SKIN :: Urticaria, Rosacea, Neurodermatitis (atopic eczema)
5. ENDOCRINE :: Thyroid toxicoses, Diabetes Mellitus, Menstrual disturbances.
6. OTHER :: Rheumatoid Arthritis.

There is much controversy regarding tuberculosis & ulcerative colitis whether these should be included under psychosomatic illness. Other conditions that have been included under psychosomatics are Anorexia Nervosa, Obesity, Psychogenic vomiting, Abdominal pain, Diarrhoea, Irritable colon, coronary thrombosis torticollis.
CHARACTERISTICS:

The essential characteristic of these disorders have been outlined in the standard Nomenclature as follows:

"These reactions repressed the visceral expression of affect which may be thereby largely prevented from being conscious. The symptoms are due to a chronic exaggerated state of a normal physiological expression of emotion, with the feeling or subjected part-repressed. Such long continued visceral states may eventually lead to structural changes" (Gregory 1961).

Halliday (1945) used the term by saying that diseases under psychosomatic category have certain characteristics quite distinct from those diseases that are primarily assigned to other broad etiological categories. He formulated a psychosomatic affection into six points:

1. Emotion as a precipitating factor.
2. A particular type of personality tends to be associated with each affection.
3. There is marked disproportion in sex incidence.
4. There is a tendency to alternation or sequence of different affection.
5. There is often a family history of the same or an associated disorder.
6. The course of the illness tends to be phasic.

In addition to these criteria characteristics of these disorders also:

7. They show disturbance of function together with damage in the organ of the body. In this, they differ from mental disorders.
8. They may occur at different periods of life in one patient.

Halliday (1945) also points out that incidence of psychosomatic affections rises and falls in accordance with the pressure of environment in its psychological as distinguished from its physical aspects.
ETIOLOGY:

An individual develops and functions as a psychobiological unit. The multiple interacting variables make it impossible to relate specific causes to particular effects, a number of conditions have been recognized that play a significant role in developing psychosomatic illness. Among these biological, psychological & sociocultural variables are considered to be prominent in developing these diseases.

A. BIOLOGICAL FACTORS:

A number of biological factors have been implicated directly or indirectly in the development of PSYCHOPHYSIOLOGICAL DISORDER. These include:

1. GENETIC FACTORS:

Since man's behavior is inevitably influenced by his biological inheritance, genetic defects are clearly a potential cause of pathophysiology. Some investigators believed that predisposition to the illness can be inherited.

There are some evidence to hold the view that genetic factors play a predisposing role in certain types of Psychosomatic illness. Solomom (1969) has pointed out that rheumatoid factor is present in the Sera of arthritis victims. The same factor in the blood is responsible for predisposing an individual to the respective disorders and not resulting from them.

The close relatives of ulcer patients have a statistically greater chance of generating ulcer than a control group of the general population (Gregory & Rosen 1965). There have also been reports of increased frequencies of other presumed psychophysiological disorders including Asthma, hypertension, Migraine, Headache and Hyperthyroidism. These increased frequencies are specific to given reaction — e.g. the relatives of the patients suffering from bronchial asthma show an increased frequency of bronchial Asthma but
not of other psychosomatic disorders. This tendency for certain, specific psychosomatic disorder is suggestive of hereditary transmission.

While it is not possible to determine the extent of hereditary vulnerability of a given organ or organ system, it should be considered that competent and conservative human genetics may have some form of hereditary predisposition.

Fraser Roberts (1959) opined that multifactorial inheritance should be taken into account as responsible for the genetic component of blood pressure. He also remarked that major genes and multiple minor genes might contribute towards the genetic component of peptic ulcer. However, the proportion of hyperthyroidism is higher in affected sisters than affected mothers which is due to underlying recessive gene or genes.

It is well known that persons with blood group of 'O' are more likely to suffer from stomach, duodenal & prepyloric gastric ulcer than patient of group A, B, or AB; while people of group A are more prone to the development of gastric ulcer to the left of the lowest point on the lesser curve (Daintree-Johnson et al, 1964). It has been found that H. Factor is always present in the superficial layer of the stomach, but is generally absent in the superficial duodenum in non secretors (Glynn 1957). It seems inherently more possible that the genes controlling blood group secretors status are connected to genes predisposing to ulceration than that they are themselves plausible (Evans D. A. P. 1961). It is presumed that certain individuals have proneness to develop these disorders under stress. However, the tendency is seemed to follow a polygenic pattern involving many genes rather than a simple recessive genetic pattern. The inherent vulnerability will not be shown by individual if he remains in a favourable life situation. This evidence of inherited predisposition is found in diabetes, high blood pressure, some form of coronary heart disease (Kaiser Foundation 1970).

There is a view that physical illness manifest in a particular organ system which are more vulnerable to stress than others. The body organ may be weakened due to poor genetic endowment or prior illness.
The persons with inherited 'weak' stomach may have proneness to gastrointestinal upsets when he becomes anxious and angry. Emotional stress may bring asthma in a person if he has had a respiratory infection causing lungs & nasal passage more vulnerable for developing this illness. Bulatov (1963) & Rees (1964) reported that bronchial asthma preceded by respiratory infection in 98 percent and 80 percent of cases respectively. Thus there is a chance of onsetting the illness in the weakest physical part rather than any direct association between any psychological stress and the specific organ affected.

Various studies indicate that the incidence of psychosomatic illness is much higher in the family history of psychosomatic but the extent to which such finding reflect the effect of heredity is not known.

2. NEUROPSYCHIC FACTOR:

Emotional factor plays an important role in developing psychosomatic illness and the exacerbation & remission of these symptoms. The philosophical problem of how psychological change produced damage to somatic organ can be elucidated by taking into account the fact that emotional changes are always followed by bodily changes.

Weil (1974) remarked that the upper limbic-hypothalamic reticular system (UHR) of the brain is the mediator of emotional & intentional behavior, the expression of which is in varieties of states, e.g. muscular tension & relaxation rhythmic movement of pleasure and unpleasure, excitement and psychosomatic visceral reaction.

The autonomic nervous system, the central nervous system, the neuro-endocrine systems represent the interrelated system of communication, where the person keeps intact equilibrium and within his own organism.

The function of the internal organ is controlled by autonomic nervous system. It has two main divisions, sympathetic and parasympathetic. Most of the organs have those double supply of sympathetic (adrenergic) and parasympathetic (cholenergic) fibres with opposing actions. In normal condition the two act together.

The autonomic nervous system is controlled by the nuclie in the hypothalamic.
The hypothalamus is involved in most visceral reaction and helps to keep the parasympathetic and sympathetic branches in balance. In psychosomatic disorder this balance becomes disrupted and results in domination of either of its two branches causing over stimulation or retardation of the gastrointestinal, circulatory and other tissues and organs that are under these branches.

The emotional states, when intense and persist for a long period, a wide discharge of impulses occur through the whole of the A.N.S., may seriously affect various organs and tissues of the body. This sometimes causes irreparable damage that threatens life.

The discharge through the A.N.S. is accompanied by activity of endocrine glands; stimulation of the autonomic supply to the medulla of the adrenal gland produces a release of adrenalin and non adrenalin into the circulation and these hormones produce in each organ the same effect as direct stimulation of the A.N. Supply. The adrenal cortex also plays an important part in the reaction to tissue damage.

The basic element of psychosomatic illness is the fact that the autonomic excitatory and inhibitory pathway that regulate visceral function are subject to influence by circuits in the forebrain, neuronal interaction that serves the interpretation of life experiences.

It is demanded that psychophysically ill persons suffer from emotional problems due to conflicting and frustrating communications in their family and work situation.

The sociocultural forces demarcate the level at which individual maintains a balance between the expression and inhibition of his emotion. This creates a situation where disharmony occurs between the expression of emotion and the psychomotor activities. These individuals repressing their emotion keep conscious awareness free from emotional feeling but physiological components of emotion remain active and this produces structural damage.
Thus it is found that A.N.S. plays an important role in the genesis of psychosomatic illness. The fact is that the reactivity of A.N.S. can not only be conditioned involuntarily following the classical conditioning method, but it can also be brought under voluntary control through the process of operant conditioning (Kamiya 1968, Dicara 1970, Schwartz, Shapiro & his colleagues 1971, Sargent et al 1970, 1971, Lang 1970, Schwartz, Budzynski & his colleagues 1973, Engel & his associates, 1974) e.g. The individual can learn to control the activity of A.N.S. as raising or lowering of brain waves, blood pressure in accordance with the instruction given to him in an experimental situation.

Turnbull (1962) was able to evoke asthma like responses in an instrumental learning situation. From works of these persons it would appear that there is a possibility, that as in the way individual learned and acquired different behavior, autonomic reactivity and visceral pattern in psychosomatic symptoms result from the unique learning experienced by him.

3. DIFFERENCE IN AUTONOMIC REACTIVITY:

The biological theory of the development of psychosomatics suggests that patterns of autonomic reactivity are inherited. They argue for a basic difference between individuals in autonomic reactivity. Young infants often show marked differences in their sensitivities to different adverse situations. Such basic differences continue till adult life and seems to have various degrees of susceptibility to psychosomatic illness.

Individuals react to stress not only differently but also have specific association of symptoms with particular physiologic mechanism. Wolff (1950) has proposed that person can be categorised as 'pulse reactor', 'stomach reactor', 'Nose reactor', and so on depending on what sort of physical changes are generally evoked by stress.

Lacey et al (1955), Lacey and Lacey (1962), Malmo and Shagus (1949), Malmo (1962) among others have suggested that a varying
range of stimuli trigger physiological response specific for the individual and continue over time. Difference in reactivity is found between patients suffering from cardiovascular symptoms and headache. The former or cardiac reactor, for example reacts to stress with cardiovascular response than muscle tension. Alternatively, an individual may show a reversed pattern in case of headache. A person who reacts to stressful situation with increased reaction of stomach acid will be more likely to develop peptic ulcer. These individual differences in autonomic reactivity seem to be stable and consistent and they aid to explain why different individuals develop different types of psychosomatic disorders.

It is evident, therefore, that hereditary predisposition may be significant in determining the development of psychosomatic illness at any period of life. There is also a question as to whether there may be a psychological predisposition to such disorders in certain individuals - possibly as a result of their family background.

B. PSYCHOLOGICAL FACTORS:

Psychological factors appear relevant to the etiology of psychosomatic illness. These include :-

1. PERSONALITY

Personality or constitutional make up of a person influence or determine the tolerance of psychosocial stress and the extent to which the emotional reaction evoked from such experience is verbally expressed or sustained. This in turn causes bodily changes by affecting autonomic endocrine function.

During the early period of life child's personality development is dependent upon the family unit. Consequently the unhealthy family unit, personality of parent, wrong childrearing practice, are the root of maladjustment & faulty development of personality. A number of studies have been conducted to find out the role of pathogenic family pattern in the development of psychosomatic disorders.
There is a history of excessive parental anxiety and demands for conformity without showing any affection or giving rewards. It results to maladjustment among the children.

The studies of Goldberg (1959), Wenar et al (1962), Lipton et al (1966), Jacob et al (1966, 1967), Olds(1970) have shown that mother of these patients have not only ambivalence restriction, overprotection towards their children but also have a tendency to reject them. The absence of father(divorce, death, too much engagement with outside) or when present if he is passive, inadequate or ineffective may facilitate to the faulty pattern of adaptation.

Block (1969) showed that psychological symptom of the child is dependent upon the parental pathology. In mother child relationship of asthmatics, they are both controlling and seductive(Knapp 1969).

Thus childhood experience affect the probability to respond to psychosocial stress. Persons coming from such environment seems to react to problems with chronic emotional mobilization.

Though there is no statistical validity but there is empirical expression that person suffering from psychosomatic illness may be the only child or have no siblings of its own age or sex.

It was noted by Rees(1976), patients suffering from psychosomatic diseases are unstable, timid, anxiety prone, sensitive, obsessive and lack in self assertion.

Many investigators(e.g. Dunber 1943, 1954) attempted to study the correlation between such illness and the patient's personality. Thus patient suffering from ulcerative colitis are rigid, obsessive and have dependent type of personality. It is difficult for them to express their feelings. Hypertensive persons tend to have rigidity, sensitivity to threat & suppressed chronic hostility.

The study of Doll(1964) & Dutta et al (1976) revealed that most of the peptic ulcer patients are neurotic, anxious & irritable.

Hamilton(1955) concluded that asthma patients have cyclothymic make up mixed with paranoid trait, repressed hostility and self punishment motives.
Halliday (1948) distinguished four main types of personality among psychosomatic patients.

1. Hysterical type: This sort of personality type is related with hysteria, in its somatic manifestation.
2. Hypersensitive and allergic type, as in asthma.
3. Self-assertive, self sufficient, over acting 'ulcer type' found in peptic ulcer and in some case of hypertension & fibrosites.
4. Self restricting, self sacrificing, rheumatoid type as in rheumatoid arthritis.

Hodgson (1945) observed that persons suffering from skin complain are chronically worrying; neurotic and over conscientious obsessive.

The view of another personality correlate theory (Graham et al 1962) regarding psychosomatic disorder is that there is a specific attitude towards stressful situation and coping reaction of an individual directly related to the specific disorder.

They found the following pattern of response of their patient toward the stimuli in their experiments:

**ASTHMA**: Out in the cold and wanted to shut the person and situation out.

**DUODENAL ULCER**: Felt deprived of what was due to him and wanted to get even (Greenfield & Stemback 1972).

Their relevancey of studying the association between attitude, stress and psychosomatic illness lies in the fact that an individual's attitude and personality constitution play an important role in determining the way he evaluates and reacts to stress (Coleman 1975).

From these studies and others Schwbel (1949), , Ostrow (1945), Moses (1946), a wide variation in personality traits is found among patients suffering from psychosomatic disorder.

Thus it can be concluded that in case of psychosomatic illness single specific type of personality is not possible to delineate.
THE PSYCHOANALYTIC HYPOTHESES:

The attempts to find out a common personality structure in psychosomatic illness were followed by efforts to find a particular psychodynamic pattern.

In psychoanalytic literature there are some theories emphasizing on the importance of regression. The persons suffering from these disorders are said to be reverted to an earlier stage of psychosexual development, e.g., in case of gastrointestinal disturbances the persons regress to oral stage which may lead to dependency. Regression to the anal stage might cause rebelliousness and resentment that lead to skin disorders. The regressive theory is based on the notion that infant's psychological activities are dominantly parasympathetic. Szasz (1952), Margolin (1953), support this hypothesis.

Another psychoanalytical theme regarding psychosomatic disorders is symbolic expression of unconscious conflict. Thus asthmatics are afraid of separation from their mother, peptic ulcer patients are assumed to symbolize their internalized aggression against their mother. The disturbances in object relation might in turn cause ulcerative colitis.

In specific emotional hypothesis Alexander (1934, 1939, 1950) asserted that there is a typical conflict of each disorders. With certain personality structure, some individuals facing a difficult life situation become threatened by emotional conflict. If this tension state becomes chronic, it finds some outlet through vegetative sphere, which affect the organ depending upon the nature and degree of induced tension. The discharge of chronic partially repressed, aggressive tendencies cause hypertensions.

There are many psychoanalytical studies in this field of Psychosomatic Research, but as the present study is not analytically oriented, no psychoanalytical literature survey has been done.

C. STRESS:

The various kinds of predisposing factors in the causation of Psychosomatic illness have been discussed - all of these conditions tend to impair the individual's ability to cope effectively with the problems of life.
Adaptive ability reflects the interplay between adjustable resources and adjustable demands. The severity of stress depends on the person's resources and on the nature of the adjustable demand itself.

The mentally healthy persons are said to be well adjusted who deal with the situations of life in a realistic way, maintaining harmony between his inner wishes and socially accepted conduct. Through balanced living good adjustment can be achieved, which can be expressed in a formula: \( A = \frac{D}{R} \), where \( A \) stands for adjustment, \( D \) is life demands and \( R \) for reaction. The behavior is balanced where \( D \) over \( R \) is equal. The well adjusted persons neither over or under react to the demand of life. This balance can be achieved by objective and realistic attitude which enable a person to perceive the life events clearly (Steckle 1956). As because childhood experiences shape the way of perceiving the life, it becomes apparent that the basis of good adjustment lies in a happy family.

As the biological, psychological needs and environmental demands are always changing, adjustment processes are ongoing continually. But if the demands are beyond one's adjustable capacities, disturbances in function take place in various aspects; such as subjective states, behavior pattern including psychosomatic disorder, psychological misery, abnormal form of thought, deviant form of behavior, the social context or failure to perform successfully or normally the everyday task according to one's capacities. To understand effective and ineffective adjustment the stress of living condition should be considered to know about stress and its consequences (Lazarus 1961).

The term stress has two common notions, the first notion means some external condition which makes sudden or extraordinary strain upon individual such as flood, wars, social changes, famine and anticipated surgery (Janis 1956, Senay & Redlich 1968).

In other sense the term used to refer to the internal state of the organism and its consequences rather than on the situation that produces it. Individuals react to stress by manifesting his general adaptation syndrome (Seley 1956, 1969). Psychosomatic illness seems to involve this chronic adaptation process to psychological danger.
Conflicts are important source of stress and often lead to such tension and inner turmoil that the individual's adjustive capacities are seriously impaired.

Alexander (1950) believed that a specific conflict which he thought as stress could be associated with a particular type of psychosomatic disorder. By suppressing this stress individual heightened his vegetative activities. If this heightened activity lasts for a longer period, pathology in viscera is resulted. For instance, passive dependent persons suffer from frustration for the need of love and protection. This frustration acts as stress. Consequently peptic ulcer is resulted by stimulating parasympathetic nervous system. The repression of conflict in a dependent person with a different genetic constituents may cause colitis or asthma.

Saul (1953) & Dudley et al (1963) also remarked that internal inhibition towards stress may lead to frustration and acute tension and as a result psychosomatic expression through the gastrointestinal tract & respiratory system respectively may occur.

Wolf (1950) emphasized on the adoptive nonspecific physiological responses to environmental stress. According to him the role of culture plays an important role in the perception of stress and the symbolic interpretation of stress.


For such psychosomatic disorders there was no evidence of specific psychosocial stress found, but in certain proportion they were important for the onset of illness (Rees 1976). The state of stress is dependent upon the degree and type of emotion and the way how a person deals with the stress state.

In addition to psychological & biological stress, there are also other stresses which are characteristics of contemporary living.
D. SOCIOCULTURAL FACTORS

To perceive all the aspects of man, his existence in society and the influence of social climate in his health and disease should be considered. The necessity of understanding social influences on psychosomatic illness has arisen from the fact that primarily it is rooted in the quality and impact of community life.

To-day the principle of ecosystem pertaining to the relationship between man and technology rather than natural environment as man is overpowered by technology. The social processes such as morbidity either geographical or social, population explosion and technological complexities are considered to influence psychosomatic illness (Mirskey 1960, Wolff 1962, Schneider et al 1963, Leighton 1963, Modline 1966, Ontong & Zones 1968). Ruesch (1965) points out that these processes are seemed to be the source of stress.

In this complex society, anxiety for the need of social recognition and acceptance is a frequent phenomena. The anxiety due to frustration of this need has been reduced by inadequate solution through physical illness which reassure the security in the environment.

According to Person (1961) society and personality are interacting, inter-dependent system and these disorders have some particular class relationship. Personality is shaped by social class as it influences the learning environment.

In the studies of Hollingshed & Redlich (1958), Mirsky (1965), Ooba (1965), Friedman et al (1968), McDermott et al (1970) psychosomatic illness were found to be common in lower class. Christenfeld (1966) found no difference of such incidence among classes and suggested that these disorders are found in those persons who have a strong and unfulfilled desires to move to the middle and upper classes.

Susser (1967) said that psychosomatic illness was more prevalent in upper socioeconomic level and have been regarded as the price to be paid for the inevitable tensions and pressures experienced
by successful executive (Kahn, 1961). Kahn (1969) found that peptic ulcer was more among workers who were dissatisfied with their jobs rather than successful executives.

Other studies (Paris & Dunham 1939), Pasamanik (1962), Rennie & Srole (1956) showed that psychosomatic illness are disproportionately high on the upper and lower classes. Arthritis common on lower socioeconomic status and colitis ulcer, rashes, hay fever, hypertension on the upper level. Senay & Redlich (1968), Katchadourian et al (1969) found ulcer, hypertension, asthma and arthritis common in all classes.

The incidence of psychosomatic illness is also common in all culture or subculture and in all races. These disorders were relatively frequent in Negroes before World War II. Halliday (1948), Staimder and Associates (1960) showed that hypertension is more common among Negroes who have moved to urban centres and this is induced by psychological stress and frustration.

Investigators found that these disorders are relatively more prevalent in industrialized societies rather than among primitive society such as in Australian aborigines (Kedson & Zone 1968) in Yoruba & in Nigeria (Leighton 1963).

Peptic ulcer is rarely reported in South America and among the Navajo Indians of Arizona (Stein 1970), whereas at the same time gastrointestinal and cardiovascular symptoms are more common among individuals who are subjected to stress. These evidences suggested that among primitive societies the incidence of this illness is few and this is due to the absence of financial stress, family disruption and uncomplicated way of life.

Each person faces a unique pattern of pressure, but in general way every one faces pressure of competing with others, meeting educational, marital and occupational demands of modern life. Many of the demands on the individuals are contradictory and thus the need to make choices and bear responsibility for them adds stress to the demands. The mere complexities of modern life overload the individuals. This overloading taxes the individual both on biological and
psychological level.

Thus there are stimuli arising from social circumstances which under certain conditions of intensity, frequency or duration and in the presence or absence of certain interacting variables (e.g., nutrition, economic conditions, physical environment) affect the organism through the medium of A.N.S. The response of individuals to the multiple of psychosocial stress of modern life may lead to structural damage.

An individual is born with certain genetic inheritance and environment determines which of the hereditary traits will be developed and to what extent. Each individual is exposed to various interaction with other persons and these relationships begin first at home. Gradually, it extends to other subgroups and experiences different interpersonal relationship. Much of his personality development reflects his experiences with these key people. Thus environment determines how his mode of behavior adjustment will be in various aspects of his adult life.

From theoretical orientation regarding psychosomatic illness it can be concluded that, besides biological factors, psychological and social factors influence greatly these sorts of illnesses.

In psychological aspects of these diseases it is found that emotion plays the major role in causing psychosomatic illness through the A.N.S. But in considering emotion as precipitating factor personality aspects of the persons should be taken into account as the tolerance of emotional stress, the defense of frustration, anxiety, tension, the expression of emotional outburst depends upon the makeup on an individual. The personality also determines how a person will adjust to his environment, not only to the members outside of his family but also to members of his family. As these disorders are chronic diseases many investigators (Burt, 1976) studied the neurotic traits of this illness. Though various studies were done in personality aspects no conclusive pattern of personality is yet established.

Other than psychological factor, social aspects of these diseases is to be taken into account the individual's responses to the social
stress may cause structural damage. It is also important to know in which socioeconomic class these illnesses are prevalent as this indicates the minimum stress and strain of that class and as personality is shaped by social class.